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Interdisciplinary teamwork

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A group of consultants of different disciplines working as a close-knit team is not a new idea in Britain, but including the patient or client in that team is a new concept when constructing an interdisciplinary team. Some of the lessons learned in working in interdisciplinary teams may have been tacitly understood in the past but in this paper Dr De Wachter expands and illustrates the philosophy behind interdisciplinary teamwork. He explains how communication grows into 'another language' and how those of disparate disciplines become one in their thinking when solving a problem together. There is an ethic of teamwork, too, which is elucidated in this paper, especially in relation to the pitfalls of power and shared responsibility. A number of case histories illustrate the argument.

The success or failure of interdisciplinary teamwork constitutes a hotly debated topic in both academic and socio-political circles. In the medical world some say that teams disturb the proper procedure for handling patients, while others consider them the only adequate way of dealing with certain complicated situations. For those concerned with the ethics of medical practice the issue looms large, and the uncritical call for and use of 'interdisciplinary teams' inevitably produces many examples of failure.

Last year Kaplan [2] wrote a brilliant critique of the artificial heart panel which had been set up in the USA. This panel proved to have been an instance of failure as far as interdisciplinary teamwork was concerned. The lack of framework and method resulted in the team's inability to cope with a complex situation with economic, ethical, legal, medical, psychiatric and social aspects. Although its function was only advisory, the panel seems to have almost totally failed even in this respect. What then would have happened had the panel been asked to decide upon whether the energy source for the artificial heart should have been the electric battery system or a nuclear fuel capsule. Yet members of all the disciplines covering each of the issues were present, but they were left pretty well to their own disciplines and biases. Valid and competent though separate judgments might have proved, the 'total picture' remained out of the committee's grasp. One suspects, therefore, that in that case interdisciplinarity had been wrongly understood as a juxtaposition of several competencies, the sum total of which would have supplied the answer to the choice of patients to be given an artificial heart. It should be made clear that not only will the sum of competencies never do, but unless rationally clarified communication can be established through a permanent 'translation' process among the different participants involved and a new scientific method is developed – or at least enhanced – no committees or teams ought to qualify as interdisciplinary.

This article is based on five years' experience as a member of a team, which includes representatives of medical and ethical fields, the 'Study and work group for fertility and sterility problems' (Louvain). This is an attempt to contribute to gradually growing insights into interdisciplinary work and methods, its opportunities and its dangers. It is assumed that our experience was in our own eyes as well as in the patients' minds sufficiently successful. The ethical importance of working in medico-moral teams will, among other advantages, appear in the benefit to the patient due to a higher quality of medical care which, in turn, seems to be directly related to the interdisciplinary nature of this team's approach.

Origins of the interdisciplinary team

So far two types of interdisciplinary team have been mentioned, namely, the scientific advisory panel on implanting the artificial heart and the team which presents itself as a study and working party in matters of fertility and sterility. But many more could be added. Usually it appears that the fields and objectives covered by the team also determine its name. Thus we hear about transplantation teams, euthanasia committees, teams for abortion, for genetic control, for artificial insemination with donor sperm and the like. What these labels in fact point to is a particular problem area where the individual competence of any specialist appears to be insufficient to cope with the complexity of a problem in its entirety. Although an issue, say abortion, may be stated in terms of medical intervention alone,

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[2]Kaplan, M B (1975). The case of the artificial heart panel. *Hastings Center Report*, 5, 41–48.

one is generally and somewhat vaguely aware of a much wider range of connected issues of a non-medical nature. Therefore an abortion team may call for the inclusion of social workers, ethicists and lawyers. Eventually, it is the very presence of all the representatives called for by the issue at stake which should determine the constitution of a given team. If the invitation to enter a team comes from, say the gynaecologist, then the risk of random and arbitrary selection is fairly high. We believe that a concrete problem, for example the undesired childlessness of a couple, should determine the type of specialists needed in such a team. In order to secure this adequate approach to the whole question it is quite helpful to make 'the person and his problem' a fully qualified member of the team as the adequate team is not made up by any number of impressive specialists but only by those called for by the very problem of the patient and his needs. Thus a team originates which is not only problem orientated but also patient orientated.

Finally, a note on the use of the word 'patient' in this article. It sometimes points to the traditional notion of a sick person calling on doctors for treatment. But very often it also indicates a less needy person, at least in the sense of need for medical help. In such cases the team faces a 'client' or a 'couple' trying to find information, counselling and assistance in their effort to reach a decision. Especially with regard to power structures and shared responsibility this nuance should be fully acknowledged.

The following crisis situation where team help was offered too late illustrates both the inadequacy of fragmented help and the need for a team to be available immediately it is needed.

Illustrative case report

Henry was a farmer's son, the only child of a first marriage. Two half-sisters were born after his father remarried. Not until these were provided for could Henry run the farm on his own. Thus he married late, at 40 years of age, a woman of 35. After a first infertile year of marriage the couple sought the advice of a gynaecologist, and for the next two years the woman's infertility was investigated and treated. Sperm analysis was rejected by the gynaecologist as immoral. The doctor, although discovering no semen in the cervical slime after intercourse, told the couple that there were not enough seed cells in the sperm. They remained, therefore, under the impression that they would have children. Meanwhile, every menstrual period brought disappointment. While Henry and his wife thought of other ways, for example, AIH, they did not dare to mention this for fear of rejection. After four years of frustration they turned to a young urologist who promptly discovered the absence of semen in a sperm sample and a biopsy of the testicle showed an obstruction in the canal. The couple was then referred to our team.

Synchronized examination of the husband and wife confirmed the urologist's findings, and operation was considered. However, the wife's fertility curve showed insufficient ovarian function. For this reason, and because she was then 50 years old and close to the menopause, it seemed too late to perform any corrective surgery on the husband. Thus the outcome was negative, and the undue delay in making an adequate diagnosis and treating the infertility of both partners seems to have caused this sad situation.

Conditions for real interdisciplinary teamwork

Under certain conditions, especially concerning the kind of communication among team members and the scientific method used, such teams may qualify as interdisciplinary. A particular quality of interdisciplinary teamwork lies in the seriousness of their communication within a coherent conceptual framework. The exchange of insights not only allows for sound judgment but also paves the way toward making decisions with responsibility fully shared by all members, including the patient or client.

THE 'OTHER LANGUAGE' OF COMMUNICATION

Communication must be serious. Suppose a gynaecologist and an ethicist meet regularly to discuss their views on such problems as contraception, sterilization, abortion. Each develops a complete argument in his own way, ie, within a given set of words, concepts and logic, and very often comes to his own conclusion. These conclusions either happen to coincide or to differ, but rarely is there that give and take which would lead to an altogether new conclusion for both of them. Until there is willingness to change one's mind and translate conviction into a language the other will fully appreciate, no interdisciplinary communication has taken place. It should be noted at once that this 'other language' does not have to be the other's language, rather, a new type of communication; a new conceptual frame is at stake. For example, a 25 per cent chance that rubella has had a teratogenic influence on a fetus may be a great worry to a pregnant woman and her doctor, whereas the inexperienced outsider may point to the remaining 75 per cent chance that there will be no such influence. A clarification of why their estimates differ so greatly would be one instance of serious communication.

But even among members of the medical profession there are divergent approaches to patients and their problems. The somatic and the psychological approaches illustrate this difference. Somatic

medicine is used to work with a more measurable, quantifiable and predictable type of problem. Very often a diagnosis can be made along lines of cause and effect, in which case it is possible to set priorities among different available therapies. All of these connexions become much looser and less apparent in the psychosomatic and psychiatric approach. The impact of 'chance' and the fact that one faces lines of evolving human freedom hardly allows for cause-to-effect relationships. In order then, to communicate seriously the gynaecologist and the psychiatrist will have to translate their own insights into another language. This 'other language', however, is a wasteland with unexpected pitfalls. It is our experience that serious communication is greatly enhanced when a team allows the client to set the stage for encounter, investigation, reflexion and decision making. In this there need be no fear of a loss of autonomy regarding one's own specialization and how to exercise it. What does happen is that one consciously abandons any claim either to monopoly or to absolute veto. Thus, a specialty is part of a wider setting and becomes integrated as to function within the frame provided by the patient. In this sense it is the client and his problem who mobilize a team of specialists and not a number of specialists who happen to work on one and the same case. It is also our experience that a more thorough investigation and a more adequate understanding of the question as a whole follows from this approach.

TEACHING THE PATIENT TO BE A TEAM MEMBER

To make the patient a member of the team, even more to let him become the one who determines the team's policy, seems to be a very doubtful adventure as 'he does not even know what it is all about!' Therefore he should be taught and made competent. Like any other patient he should have sufficient insight as to the diagnosis of his problem as well as to the different therapeutic possibilities. Similarly he can learn how to select therapies according to what fits him best, physically, psychologically, socially, humanly. His profession and his family and his own and their level of tolerance and strength should be given due consideration. Again it is our experience that this type of involvement of the patient results in adequate help and effective therapy.

Thus, not only the patient but all other team members participate equally in a common cause, toward which they develop an attitude of common responsibility. The patient is not left with the impression that several specialists consecutively scrutinize his 'case' and then, after some secret session, decree what will be done to him. But neither are any of the other team members singled out for some job no one has mentioned thus far. Therefore the gynaecologist, who is the only one to use the scalpel competently, never feels like a technician carrying out other people's decisions. Even though juridically he may be singled out as the one accountable, morally he is backed up by a team and a common decision. Much, if not all, depends therefore on the previous decision-making process. To the extent that consultation, investigation, the maturing and the making of the decision has been a common enterprise (including the gynaecologist's active participation) he will know that all are with him, that the decision is fully his own. Here no order is being given from without but a decision has been reached from within. Shared responsibility, then, is a real part of interdisciplinary teamwork (at least in teams which are expected to come to a decision).

Another case from our own experience may show how this approach to a problem can work with the cooperation of the patient. The case presents some remarkable features in that this couple had practically decided on sterilization but were unable to decide which partner should be sterilized.

Illustrative case 2

John and Mary had been referred to the gynaecologist of our team who felt that some psychological assistance was needed. Instead of sending them home with the request that they make up their minds about sterilization and if they so wished come back to the appropriate consultants for operation, he told them about our team.

John (aged 36) and Mary (aged 35) had been married for seven years. They had three children, all of them planned and desired. Spacing them had been successful, despite several changes in the methods of contraception. Such changes had always been made after consultation with their family doctor. Gradually, however, they felt that another 10 years or so of temporary contraception would become an unreasonable burden, and therefore they desired a permanent and definitive form, sterilization. John felt that he should be the one to be sterilized because so far Mary had carried most of the burden of contraception. Mary was equally willing to be sterilized but reasoned that in the event of her death her husband as a sterilized widower with three children would have fewer chances of remarriage.

This situation offered an ideal opportunity for the gynaecologist to inform the couple about present developments and techniques in male and female sterilization, and of the conditions, implications, repercussions and especially of the question of reversibility or otherwise. The psychiatrist had been able to help them in assessing the termination of their fertility potential as a couple (the so-called mourning process). During this period it became more and more clear that within the strong bond of their relationship the sterilization of Mary offered the best prognosis.

Working in an interdisciplinary team, the individual specialist after a time suddenly finds himself acting in a new way, doing things differently and also doing different things. What he previously knew as very difficult, too risky and complicated has been drawn within the range of adequate treatment. Due to teamwork new insights and new ways of handling patients and their problems can be realized. If previously he may have suffered from the shortcomings of highly specialized and fragmented performances, he now experiences the more wholesome team approach as a reward.

Ethical issues

Interdisciplinary teamwork provokes a number of ethical questions, all the more so if the team is supposed to reach a decision beyond its advisory function. Some of these issues are inherent in interdisciplinary teamwork, and inevitably arise at one time or another during the team's performance. An example is the question of power, the process whereby a decision is being reached, the sharing of responsibility, the determination of criteria for decision, their definition and impact. A striking example of the latter is the often invoked, yet rather arbitrarily defined criterion of 'meaningful and/or worthless human life'. Other ethical issues only occasionally arise. They are indirectly connected with interdisciplinary work. Thus, for example, the opinion that teams disturb the normal procedure and threaten the relationship between a physician and the patient; or again, the role of a man's philosophy of life, or of the image one held of man and society, or the importance given to social pressure. It is certainly not feasible here to elaborate on each and every single issue of our tentative inventory. However, two ethical issues have proved to be of such importance that they may be given somewhat fuller attention, namely, the power structure connected with teamwork and the question of shared responsibility.

POWER

The fact that abortion is or is not being performed depends in most cases on the doctor's willingness or refusal to act. This has caused several people to raise fundamental questions with regard to the power a doctor holds over his patients. Who entitles him, or a team for that matter, to say yes or no to a woman's request for abortion? Is not every team by itself a sign of arrogance and presumption, a violation of people's basic right to freedom and self-determination? Moreover, is not every team a cover for responsibility which the whole of society foregoes? Some, therefore, say that all teams breed abuse of power.

It is however important to face the fact that working as a team inevitably entails a deployment of power. A team produces power from within because of its members' technical skill and competence. Its capacity to guarantee adequate help automatically creates some sort of 'superiority' over those who look for such help. This superiority is very often reinforced by a patient's inability to cope with a problematic situation. Another questionable yet real source of power appears where society does not want to leave certain decisions indiscriminately in the hands of individuals. Rather, power is being 'delegated' to a team. Thus, from the very start patients or clients find themselves in a situation of helplessness and dependence.

Although we do not believe that all power necessarily corrupts, a few warnings against possible abuse of power seem to be in order. The refusal of a patient's request should be thoroughly accounted for. Very often the refusal is justified by saying that harm would be done to the patient or to others. But if the patient is left with all the consequences of this non-intervention, he should be granted the opportunity to question or refute. In other instances a more subtle version of this justification for refusal refers to the scarce availability of teams and the apparent or real necessity to select for treatment. While often very realistic, such an explanation need not be taken for granted. If the treatment of certain situations calls for team assistance, then the creation of more teams would probably be a more adequate answer. In yet other cases where team assistance is being offered, the effect appears to be counterproductive. Pluralistic societies may be correct in claiming the patient's right to articulate his request and to make up his own mind, for example, in matters of sterilization. In this setting a team might counteract such a tendency by maintaining a taboo on sterilization. And finally, a team could become a psychological burden for the patient. Whenever guilt feelings flow from contacts with a team, one would tend to disqualify the help as inadequate.

These dangers, however, need not materialize in all instances of teamwork. Provided a patient is made to participate in the decision-making process, the chances are real that no abuse of power takes place. Similarly, unless there is proof of exploitation, the correct exercise of power may be presumed.

In this connexion it is also useful to point out that the awareness of powerlessness offers a quite effective antidote to team members. Usually these members are well aware of many threats to their competence in giving adequate help. Teamwork is a time-consuming business not only for the members of the team but also for the patient. Furthermore the lack of a sufficient number of teams to handle all requests makes a team aware of its limitations. Finally, teams should be conscious of a subtle tendency in society to abuse them. Indeed, medical labels frequently serve to cover problems of a much wider nature. Physicians should protect themselves against the possibility of

an unjust situation in which they are asked to make decisions on cases requiring the competence of people from other disciplines, such as social workers, moral philosophers, politicians. An example of such abuse would be the very questionable reduction of complicated abortion problems to the merely 'medical indication'.

The ethical issue of power and its use by a team, according to our experience, could be handled rightly through the following procedure: 1) the patient and his request should be received and acknowledged in its human dimension, that is, beyond being a 'case'; 2) all members should be willing to clarify their own motivations and reasons and be equally willing to listen to others without prejudice; 3) responsibility is to be shared by all alike; 4) a follow up of patients should be guaranteed even to those whose request has not been granted; 5) the team must not work secretly but in the open, with its own professional and social identity.

The power issue was particularly felt by our team on the occasion of a woman's request to have an abortion, as the following case history will show.

Illustrative case 3

Mrs X (aged 30) was a tiny, thin, tired woman who did some light cleaning work in the hospital. Her husband was an inpatient in a special clinic for multiple sclerosis. He had been allowed to go home for a long weekend at Christmas, during which period they had unprotected intercourse, resulting in a pregnancy. Mrs X had not told her husband about this unexpected and unwanted pregnancy (now in the tenth week) because he was guilt ridden and very depressed. She was hardly able to carry on under the burden of work, two young children and the daily concern for her husband. Moreover she had a cardiac condition. She asked for interruption of the pregnancy with very mixed feelings. As a Catholic she feared that her request was a violation of God's will. At the same time she could not see how it would be humanly possible to see the pregnancy through, nor how such a burden could indeed come from God.

After her consultation with the gynaecologist and psychiatrist in the team, it was decided to ask a cardiologist for more specific information. Even then some members of the team were wondering if it would not be better to terminate the pregnancy immediately. Yet, the moral qualms felt by the patient and our awareness of our duty to help her to clarify the issue for herself instead of taking the decision ourselves, counselled us to wait. The cardiologist advised termination without delay although he was opposed to abortion. The whole decision-making process came to an abrupt end when Mrs X's family doctor called for her admission to hospital, as his patient was having a spontaneous miscarriage.

SHARED RESPONSIBILITY

A second ethical issue concerns the problem of shared responsibility throughout the whole process of decision making as well as afterwards when the consequences have to be faced. While coresponsibility seems to be the true way for a team to exercise responsibility, there can be no doubt as to its delicate nature. First, there exists within every team an almost natural tendency toward polarization: one of the members dominates some or all the others, the team is paternalistic towards the patient, or the patient controls and orders team members around. Second, shared responsibility is endangered whenever there is persistent disagreement. In order to solve this dissent, all members should be equal in 'voting' on any issue. In other words, no individual member of the team or individual argument should be ignored. No one must be reduced to the position of executor of others' decisions. Thirdly, a team decision must never be rushed by jumping to conclusions. Rather, an 'expectant' attitude should be fostered, even if this consumes time. Especially in situations where the participation *ad hoc* of specialists from outside the team is required, their tendency immediately to draw final conclusions on the basis of their 'partial' insight should be avoided. And fourthly, shared responsibility must never become a substitute for individual responsibility. It would be a great pity if the level of personal responsibility were to be lowered because of a feeling that others are also responsible. Surrendering responsibility has never been a sign of virtue. It may be useful, therefore, to keep a constant eye on the warning signals of a routine developing. Whenever new patients are being treated as already familiar cases, something might be going wrong in the way responsibility is being shared.

Nevertheless, despite these dangers we still hold that shared responsibility lies within reach of sound interdisciplinary teamwork. In order to secure its quality the following recommendations may be helpful. The content, reasons and impact of both individual and common appraisal should be clear. Unanimous consent about the final decision is desirable. In order to ascertain the maturity of a decision a prospective and expectant attitude should be given its full measure. The harmonious combination of individual and common responsibility offers real chances for the ethical quality of the decision. Furthermore, it must be made clear that shared responsibility in no way equals the sum total of all individual options. Rather, coresponsibility rests upon sound judgment and decision which, in turn, flow from a process of interdisciplinary approach. What really matters in this process is not only the technical opinion of a specialist but the fact that his opinion can be translated and transferred to others and towards a focal point, the problem and its solution, and each specialist's opinion should be made available, under-

standable and acceptable to other members of the team, including the patient.

Our last illustrative case history shows how a couple came to share responsibility by the help given to them in making their gradual decision to use AID.

Illustrative case 4

Mr and Mrs Y had been married for 12 years. He was 36 and a truck driver, she 30 and a seamstress. For several years the absence of children had been no particular problem, but in the last four years they began to have a strong desire to have children. Mr Y's capacity to express his thoughts and feelings was somewhat limited, and Mrs Y, although not domineering, was the one who was intellectually ahead; she formulated well both for herself and for her husband. At one stage of the decision process, when reading one of the best known informative booklets on AID, she had to interpret the contents for him.

Within four months it had become clear that Mr Y was permanently sterile, whereas Mrs Y had a quite satisfactory fertility potential. While strongly desiring to have children, they were not ready to decide at once which of the alternative ways of achieving parenthood to choose: adoption, fostering, or a baby conceived by AID. To have adoptive or foster children seemed to them too much of a risk. As well as there being a shortage of babies available for adoption and a waiting period of three years, they were not willing to face the disappointments often encountered with adopted children. What attracted them strongly to AID, as they told us repeatedly, was the fact that here was a way of gradually growing into parenthood. Pregnancy, they felt, would mean a lot more than having a child which would be biologically half their own. The very fact of talking of this possible growth experience had already brought them closer together in the two months since they had known about the husband's sterility.

We, for our part, felt that it was an extraordinary result of teamwork with and for the client when this couple came with their final decision that 'thanks to your help, we have elected to be candidates for AID'. Indeed what better words can there be to describe this important function of a team than to help patients to decide which of the available treatments to choose.

Conclusion

Critics who say that interdisciplinary teams disturb the right procedure for handling patients may have a point. In a number of instances there is no interdisciplinary teamwork but only an attempt to follow the latest fashion. Moreover, experience proves that interdisciplinary teamwork is not by itself a guarantee of responsible action by all of its members. Nevertheless, a number of assets can be listed to support interdisciplinary work and even show its true necessity. The 'wholesome' approach in a patient-orientated team is probably the chief assets. For the ethicist engaged in medical questions it would seem as though the method of interdisciplinary teamwork is one outstanding occasion to contribute to the human quality of good medicine as well as to deepen his own ethical perception and awareness of the medical world. Both medicine and ethics, therefore, may gain from the truly interdisciplinary teams.